PRINTED: 05/22/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
							R
		09G037	B. WI	NG _		0:	5/15/2008
NAME OF P	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENT	rs	(W 0	00}			
	level of compliance submitted in respor recertification surve to assess the level deficiencies cited in presented in their Fresults of the surve staff interviews, as and administrative the unusual incident A recertification sur 2, 2008 through Approcess was utilized clients was selected of seven males with disabilities. The surposervations in the programs, interview including unusual incomplete including unusual incomplete incomplete facility's Qualification of the safet immediate jeopardy remained onsite un serious and immed plan that prohibited program until his miner incomplete in the survey including unusual incomplete incompl	ey. The survey was conducted of compliance to the a the previous report and as Plan of Correction (POC). The ey were based on observation, well as a review of the client records, including a review of at reports. Every was conducted from April 11 4 2008. The full survey ed. A random sample of four defrom a residential population on mental retardation and other revey findings were based on group home and at four day as and a review of records,				7000 JUN 12 P 12: 08	BEPARTMENT OF HUACTH HEALTH RECYLLATION ADMINISTRATION
	protect Client #1 fro						
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATU Ŕ E	<u> </u>	TITLE /		(X) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QX2O12

Facility ID: 09G037

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUI		J	R		
		09G037	B. WIN	IG		05/15		
C M S	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)			HOULD BE COMPLETIO		
{W 000}	Continued From pa	ge 1	{W 0	00}				
{W 102}	The outcome of the failure to be in com	e survey resulted in the facility's pliance with the Conditions of rerning Body and Client	{W 1		Cross reference W104 am	nd W127	6/20/08	
		sure that specific governing nent requirements are met.						
{W 104}	The facility's govern general operating densure the provision clients' health and so the facility's Govern govern the facility in clients' were free free 483.410(a)(1) GOV The governing body budget, and operating	/ must exercise general policy, ng direction over the facility.	{W 1	04}				
	Based on observati review, the facility's monitor and/or revis ensure its client 's appropriate to prom well as active treatr	s not met as evidenced by: on, interview and record Governing Body failed to se its operation directions to are provided an environment note the health and safety as ment services for its residents. Ice was observed for one of s. [Client #1]						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G037	B. WING		05/15	R 5/2008
NAME OF F	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 104}			{W 104}			
	recertification surver. Client #1 is transition suitable to his age at the afternoon of 5/13:45pm revealed Conavigating the step home from the van his day program. Tapproximately 19 massistance of four of way up the steps at Earlier in the day, in House Manager (House House House House House House House House House House Manager (House House H	ed during the 4/4/2008 ey for failing to ensure that oned to an environment more and mobility. Observation on 15/2008 at approximately lient #1 had extreme difficulty s leading up to the door of his when he arrived home from		Client#1's DDS case manamitted a referral for a free environment on 4/8, CMS, Inc. Program Direct mitted a letter to Cliencase manager, attorney, guardian to identify	barrier /08. tor sub- nt#l's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G037	B. WING		R 05/15/2008	
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		HOULD BE COMPLÉTION	
{W 104}	Continued From page 3			4}		
{W 122}	the assessments sta. Gait: he has absassistance. b. Mobility: one - to. Functional distrated independently. This citation could raws still residing at placement had not 483.420 CLIENT P	normal gait, which requires wo staff [required] ance - approximately 15 - 20 not be abated, as the client the facility and a viable been identified to date. ROTECTIONS sure that specific client	{W 12	a barrier free facility Client #1. A case confibe held with the team the referral being proposed and Client #1's current status and his support time. The QMRP will conformed to communicate with Client DDS case manager twice regarding the status of referral for a barrier placement.	erence will to discuss cessed s it functional is at this intinue to it #1's a month of the	
	Based on observation review, the facility of safety of each client were served in accordictary orders [See barrier free environ and safety risk [W1]. The effects of these the failure of the facensure their health. Previously cited in the Survey: Based on observation review, the facility of the facility of the facensure their health.	e systemic practices results in cility to protect its clients and to and safety. the 4/4/2008 Recertification on, interview and record ailed to ensure the health and				
		alled to ensure the health and to the health and the h				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G037	B. WIN		R .	
	ROVIDER OR SUPPLIER	030037		STREET ADDRESS, CITY, STATE, ZIP COL 3815 ALBERMARLE STREET NW	•	5/2008
CMS				WASHINGTON, DC 20008		ė
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION : TAG CROSS-RÉFERENCED TO THE A DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE
{W 122}		_	{W 12	22}		
	dietary orders [See parents/guardians v incidents [See W14	ordance with prescribed W127]; failed to ensure were notified of serious [8]; failed to implement policies at ensured clients' health and		Cross reference W127 Cross reference W104		6/20/08
	safety [See W149]; injuries of unknown W153]; failed to en- more restrictive tec documented that pr intrusive techniques were ineffective [Se barrier free environ and safety risk [W1	and failed to ensure that all asource were reported [See sure that prior to the use of hniques, the client's record rograms incorporating less had been attempted and ee W278]; failed to provide ment to ensure client's health 04]; and failed to provide 1:1 are clients' health and safety				
{W 127}	the failure of the fac ensure their health	e systemic practices results in cility to protect its clients and to and safety. TECTION OF CLIENTS	{W 12	27}		
	Therefore, the facili	isure the rights of all clients. Ity must ensure that clients are hysical, verbal, sexual or e or punishment.				
	Based on observation review, the facility for received their meal prescribed in their control of their contr	s not met as evidenced by: on, staff interview and record ailed to ensure client 's s in the form and texture as dietary orders, for two of the s. [Clients #1 and #6]				
	The findings include	e:				
	The facility was pre	viously cited for failing to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G037	B. WING		R 05/15/2008	
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 127}	ensure that clients of diets received their consistency as required habilitation plans. To compliance with this compliance with this 1. Observation on 5:15pm revealed Clapproximately 12 - pureed diet. At app was observed drink milk in the cup was regular (poured) con Record review reveassessment dated sinformation: a. "[Client #1] corr blenderized pureed (pudding consistency for thickener which is a liquids. A Modified last conducted in M Hospital Center. A phase of swallow we choking were noted initiation." c. [Client #1] tolera diet with thickened linterview with the fat 5/15/2008 at 3:16pm	with modified food texture meals in the form and uired by their approved. The facility was still out of a section as outlined below: the evening of 5/14/2008 at lient #1 was served. The dient #1 was served. The dient #1 ing his milk. As he drank, the observed to move around at a misstency as he drank. The aled Client #1 is Speech. The dient with thickened liquids. The dient with thickened liquids. The dient was allow study was ay 2001 at Washington moderate to severe oral as detected. Coughing and to occur after swallow. The dient washington moderate to severe oral as detected. Coughing and to occur after swallow. The dient washington moderate to severe oral as detected. Coughing and to occur after swallow. The dient washington moderate to severe oral as detected. Coughing and to occur after swallow. The dient washington moderate washington moderate washington moderate to severe oral as detected. Coughing and to occur after swallow. The dient washington moderate washington washington moderate washington w	{W 127	· · · · · · · · · · · · · · · · · · ·	diet and foods/ Manage- aff's	
	served. The facility	' thickened " before it was failed to ensure that Client #1 at the form and consistency ech assessment.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G037	B. WIN				R 5/2008
NAME OF F	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 127}	2. Observation on 5:21pm revealed C portioned meal of M Chicken, and mixed sliced carrots). The and cooked well an #6 was later served desert to round out meal, he was observationary assistance. At 5:30 staff realized Client cutting up his chick meat up into smalled Client #6 continued process, the facility interviewed about the requirements for all While detailing event textures, he stated mechanically soft do Client #6 's Nutrition 8/2/2008 recomment 1500 calorie, Mechillon The facility failed received his meal in outlined in his Nutrition of the facility failed received, the facility failed review, the facility failed review failed	the evening of 5/14/2008 at lient #6 was served a whole flacaroni & Cheese, Baked divegetables (cabbages and e baked chicken appeared firm did did not appear moist. Client a bowl of sliced peaches as his meal. At the start of his rived eating without staff opm, one of the direct care #6 was having a little difficulty en, walked over and cut the er portions (bite sized) for him. to eat his meal. During the 's House Manager was he required food texture the clients sitting at the table. Tyone 's required meal that Client #6 's required a "iet". Record review revealed, and assessment dated anded that he receives a "anically Soft, Low Sodium diet. To ensure that Client #6 the form and consistency as tional assessment. The 4/4/2008 Recertification on, interview and record ailed to ensure the health and by making certain all meals ordance with prescribed one of the four clients (Client	{W 1:	27}	2. An in-service was hel 5/23/08 on Client #6's d the preparation of his f liquids. In the future, ment will supervise staf preparation of Client#6' weekly.	iet and oods/ Manage- f's	6/20/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		09G037	B. WII	1G		R - 05/15/2008		
NAME OF F	ROVIDER OR SUPPLIER			381	ET ADDRESS, CITY, STATE, ZIP CODE 5 ALBERMARLE STREET NW ASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE		
{W 127}	program provided of prepared in accordadietary order. The finding includes A. Observation of to f April 2, 2008 at a staff interview revealishsticks, creamed water and peaches and his beverages water and peaches and his orders are vealed he was prelow cholesterol pure be added to his lique. Observation at Clief 2008 at approximate	ensure Client #1's day Client #1 with meals that were ance with his prescribed s: he dinner meal on the evening pproximately 5:47 PM and aled Client #1 was served corn, collard greens, milk, Client #1's meal was pureed were thickened. A staff r observed to be situated next his meal. It should be noted also observed to be v of Client #1's April 2008 on April 3,2008 at 4:47 PM escribed a low sodium, low fat, eed diet and thickener was to ids. ht #1's day program on April 4, eely 11:48 AM revealed the	{W 1	27}	DEFICIENCY)			
	client seated at a ta with his peers. Clos with the day prograr eating greens, brea- cheese, juice and m however, that Client bite sized pieces; th the prepared collard served without any s form and/or consiste dietary order. Conti- that staff were prese- intermittently left the	ble in a room eating lunch ser observation and interview m staff revealed the client was ded fish fillet, macaroni and nilk. It should be noted that should be noted and special modifications to their ency as required by Client #1's nued observation revealed that in the dining room but the room. Day program staff to be continuously by his side						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		09G037	B. WING	3	R 05/15/2008		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W 127}	program staff monit she was aware of the aware that the client textured diet. The so- client's dietary orded thickened beveraged the served meal in the correct textured members failure to texture concern, the who was responsib meals at the day pro- replied that it was the staff member at the	was eating his lunch, the day coring the meal was asked if the client's dietary order and thad not received the correct staff person acknowledged the ras a pureed diet with es, but failed to intervene with order to provide the client with diet. Due to the staff address the observed food e staff member was asked the for preparing the clients' orgram. The staff member he responsibility of another day program and further esponsible staff person was in	{W 12	7.7}			
	responsible for prep 4, 2008 at 11:52 AM aware of Client #1's According to that st was to be pureed or further revealed a dkitchen, that indicat No Added Salt (NAS pureed diet with this member was inform meal that was serve he could eat it in the Interview was condinurse on April 4, 20 Client #1 was to have at risk for aspiration informed that Client	ucted with the staff person paring Client #1's meal on April II to ascertain if she was prescribed dietary order. aff person Client #1's meal rechopped. The staff member ocument, located in the ed Client #1 was to receive a S), low fat, low cholesterol exhened liquids. When the staff red of the consistency of the ed to Client #1, she indicated e manner it was served. Sucted with the day program 08 at 12:04 PM that revealed we a pureed diet due to being when the nurse was #1's meal was not served as necliately stopped the client					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G037	B. WI	NG		R 05/15/2008	
NAME OF F	PROVIDER OR SUPPLIER			381	ET ADDRESS, CITY, STATE, ZIP CODE 5 ALBERMARLE STREET NW ASHINGTON, DC 20008		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 127}	from eating and tolor prepare another methis dietary order (put). B. Interview was confacility's former Hou Qualified Mental Research (QMRP) on April 4, Client #1's dietary on why the client was put thickened beverage Client #1 received a liquids due his risk of the Review of Client #1 approximately 7:35 language evaluation. According to the ashistory of aspiration Barium Swallow stude 2001 at Washington to severe oral phase Coughing and chooks swallow initiation. Of assessment revealed documented that Climblenderized pureed (pudding consistence eating at mealtimes with the tendency to show the State of the	the kitchen staff person to eal for him in accordance with areed). Inducted with the residential see Manager (HM) and stardation Professional 2008 at 5:13 PM to verify order and ascertain the reason prescribed his pureed diet with see. According to the HM, a pureed diet with thickened for aspiration. Is records on April 4, 2008, at PM revealed a speech and adted August 1, 2007. Is sessment, "Client #1 has a of thin liquids. A Modified dy was last conducted in May a Hospital Center. A moderate see of swallow was detected ing were noted to occur after continued review of the ed a recommendation that to one supervision at d." The assessment also ient #1 tolerated a I diet with thickened liquids by)." It further described his and indicated that he had	. ·	27}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		09G037	B. WIN	IG				R 05/15/2008	
NAME OF P	ROVIDER OR SUPPLIER	***	•	38	15 ALBERMA	CITY, STATE, ZI IRLE STREET N N, DC 20008		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			ULD BE	(X5) COMPLETION DATE
{W 127}	#1's health and safe onsite until the facil immediate jeopardy prohibited Client #1 until his mealtime s addressed. The su Client #1 from pote 483.430(a) QUALIF RETARDATION PR Each client's active integrated, coordina	ety. The surveyors remained ity addressed the serious and by by initiating a plan that 's return to the day program ervice at the program was apport was designed to protect nitial harm.	{W 1:						,
	Based on observati review, the facility f active treatment pro coordinated and mo Mental Retardation of the four sampled that resided in the f	•							
	Professional (QMR be served meals in	Qualified Mental Retardation P) failed to ensure that clients the form and consistency as bilitation plans. [Reference			1. Cross	reference	W127	<i>#</i> 1	6/20/08
{W 194}	Professional (QMR was trained and are client 's habilitation	Qualified Mental Retardation P) failed to ensure that staff e able to effective implement a n plan. [Reference W194] FF TRAINING PROGRAM	{W 1		2. Cross	reference	W127	# 2	6/20/08
	Staff must be able	to demonstrate the skills and							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		09G037	B. WIN	IG _		R 05/15/2008		
NAME OF P	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF OUT OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO TO DEFICIENCY		HOULD BE	(X5) COMPLETION DATE	
{W 194}	techniques necessal program plans for exprogram plans for expressions program plans for expressions and the second plans are the second program sampled clients. (Constitution of the finding includes the second plans are	ary to implement the individual each client for whom they are so not met as evidenced by: on, interviews and the review ty's staff failed to demonstrate implementation of each clients Plan (IPP) for two of the four clients #1 and #6)	{W 1	94}				
	5:15pm revealed Cl thickened "before revealed, his curren 8/2/2007 recommer at a "pudding thick W127] 2. Observation on 5:21pm revealed Cl served in a mechan review revealed, his assessment dated 8	the evening of 5/14/2008 at ient #1 's liquids were not "being served. Record review it Speech assessment dated inded that his liquids be served." consistency. [Reference the evening of 5/14/2008 at ient #6 's meal was not ically soft texture. Record current Nutritional 8/2/2007 recommended that mechanically soft diet ".			1. Cross reference W127 2. Cross reference W127		6/20/08	
	·- ·							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R	
		09G037		B. WING _	_		15/2008
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
CMS				SERMARLE S STON, DC 20			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
{1 000}	INITIAL COMMENT	TS		{1 000}			
{I 180}	verify the level of co correction submitte survey. The revisit value of compliance previous report and Correction (POC). based on observational review of the client including a review of the client including a review of the client including a review of the client including a review of the annual relicensuration and an annual retardation as survey findings were the group home and		an of 4/4/2008 sess the ited in the r Plan of rvey were is well as records, at reports. icted A elected ales with The ons in is,	{I 180}			
	Each GHMRP shall administrative supp						
	Based on observation of records, the facili competency in the in	met as evidenced by on, interviews and the ty's staff failed to der mplementation of ea Plan (IPP) for two of clients #1 and #6)	e review nonstrate ch clients				
	The finding includes	5 :					
		viously cited during to nducted on 4/4/2008					
ealth Regista	ution Administration ULTAVALLE URECTOR OR PROVID	Wille.	FATIVE'S SIG	NATURE #	TITLE O	+	(X6) DATE
TATE FORM	1	2.00011 BLICKLEPRESEN		899 Q	VODE	If continua	e//// ation sheet A of

STATEMENT OF DEFICIENCIES

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED		
		09G037		B. WING_		I	R 1 5/2008		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 00/	10/2000		
CMS				BERMARLE STREET NW GTON, DC 20008					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETE DATE			
{ 180}	to ensure that its staff showed competency in implementing a client 's individual program plan. As cited previously, the facility was still found to be out of compliance with this section as exampled below: 1. Observation on the evening of 5/14/2008 at 5:15pm revealed Client #1 's liquids were not "thickened "before being served. Record review revealed, his current Speech assessment dated 8/2/2007 recommended that his liquids be served at a "pudding thick" consistency. [Reference 3510.5(f)]			{I 180}					
					1. Cross reference W12	7 #1	6/20/08		
	5:21pm revealed Cl served in a mechan review revealed, his assessment dated 8	8/2/2007 recommend mechanically soft di	not lecord ded that		2. Cross reference W12	7 #2	6/20/08		
	recertification surve Client #1 was transi more suitable to his Observation on the approximately 3:45g extreme difficulty na to the door of his ho arrived home from I took approximately assistance of four d way up the steps ar Earlier in the day, in House Manager (HI revealed he has not ability to ambulate in has been refusing of	cited during the 4/4/y for failing to ensure tioned to an environing age and mobility. afternoon of 5/15/20 cm revealed Client # avigating the steps lead to the term of the van whis day program. The 19 minutes and requifferent staff as he may be a state of the term of the house at 4 terview with the facily on 5/15/2008 at 3 ticed a decline in [Client of the house at 4 terview with the facily on 5/15/2008 at 3 ticed a decline in [Client of the house at 4 terview with the facily on 5/15/2008 at 3 ticed a decline in [Client of the house at 4 terview with the facily on 5/15/2008 at 3 ticed a decline in [Client of the house at 4 terview with the facily on 5/15/2008 at 3 ticed a decline in [Client of the house at 4 terview with the facily of the house at 4 terview with the house at 4 terview wit	e that ment 08 at 1 had ading up en he e process sired the nade his 4:04pm. ity 's:22pm ent #1 's] Client #1] view with	·					

Health Regulation Administration

QX2O12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 1		:R/CLIA MBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	!	09G037		B. WING_			R 5/2008	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE		J/2000	
смѕ				BERMARLE STREET NW GTON, DC 20008				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE		
{ 180}	Continued From page 2 {I 180}							
	revealed, "The face meetings regarding suited facility. His public his needs because housemates and the placement is not agone level placement his mobility." In accommodification of the face of the	P) on the same day a cility has taken part in a having him placed in placement here does of the activity levels are fact that the currenge appropriate. In addition, Client #1's Fent dated 7/26/2007 d	n several n a better s not meet of his nt Idition, a address Physical		Cross reference W104		6/20/08	
	a. The following Comments were written: [Client #1] ambulates with severely hip and knee flexion. He has decrease stride strength and poor endurance. He has increased hip flexion and knee flexion 2 degrees to postural limitations. He requires assistance with getting off the van.							
	the assessments striction i. Gait: he has about assistance. ii. Mobility: one - to iii. Functional distartion feet independently. This citation could now as still residing at the independent of the inde	normal gait, which re wo staff [required] ance - approximately not be abated, as the the facility and a viab	equires 15 - 20 e client					
{ 229}	3510.5(f) STAFF TF	been identified to dat		{ 229}				
(am shall include, but		(1 ZZ9)				
	residents to be serve to, behavior manage	related to the GHMRF red including, but not ement, sexuality, nut nmunications, and as	limited rition,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			eted R	
		09G037				05/1	15/2008	
NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
CMS				STON, DC 2	STREET NW 0008			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETE DATE		
{I 229}	technologies; This Statute is not Based on observatireview, the facility freceived their meal prescribed in their of four sampled client. The findings included the facility was preensure that clients diets received their consistency as required their consistency as required the facilitation plans. The facility was preensure that clients diets received their consistency as required and the facilitation plans. The facility was required the facilitation plans. The facilitation plans is the facilitation plans is the facilitation plans. The facilitation plans is the facilitation plans is the facilitation plans. The facilitation plans is the faci	met as evidenced by ion, staff interview ar ailed to ensure client in the form and text dietary orders, for two s. [Clients #1 and #6 e: eviously cited for failing with modified food text meals in the form are uired by their approve the facility was still os section as outlined in the evening of 5/14/10.	od record I's ture as to of the I of th	{I 229}	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
	" [Client #1] continu pureed diet with thic consistency). He re thickener which is a	ues to tolerate a blen ckened liquids (pudd eceives Thick-n-Easy added to his liquids. "	derized ing /					
	5/15/2008 at 3:16pr should have been ' served. The facility	acility 's House Mana m revealed Client #1 "thickened "before of failed to ensure that at the form and consect assessment.	's milk it was : Client #1			•	·	

Health Regulation Administration

QX2O12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI					E SURVEY PLETED	
		09G037		B. WING_			R	
NAME OF R	PROVIDER OR SUPPLIER	090037	STREET AD	DRESS CITY	STATE, ZIP CODE	05/1	5/2008	
CMS	3815 ALE				STREET NW			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
{ 229}	Continued From pa	ige 4		{I 229}				
	5:21pm revealed C portioned meal of N Chicken, and mixed sliced carrots). He sliced peaches as heal, he was obserstaff assistance. A attending to the me food into smaller pocontinued to eat his the facility 's House about the required all the clients sitting everyone 's require that Client #6 's rediet". Record revious Nutritional assessme recommended that Mechanically Soft, I facility failed to ensure that the construction of the constructio	the evening of 5/14/client #6 was served a Macaroni & Cheese, Ed vegetables (cabbage was later served a behis desert. At the state of the seal walked over and cortions (bite sized). Os meal. During the pree Manager was interved texture requirement at the table. While of at the table. While of the seal walked over and cortions (bite sized). Os meal. During the pree Manager was interved at the table. While of the table while of the table will be the table of the seal textures, he seal walked 8/2/2008 in the receives a " 1500 Low Sodium diet. " The seal of the table of the seal of the table of the seal	a whole Baked ges and gowl of art of his without staff cut his Client #6 rocess, viewed nents for detailing stated ally soft #6 ' s 0 calorie, The ceived his		Cross reference W127 #2		6/20/08	
{ 500}	that the rights of res	dence director shall e sidents are observed	and	{ 500}				
	chapter, and other a laws. This Statute is not Based on observati	lance with D.C. Law 2 applicable District and met as evidenced by ion, interview and reconstruction failed to ensure the client's rights.	d federal					
	The findings include	e.						

Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/SUPPLIER/CLIA CATION NUMBER:		IPLE CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED	
		09G037		B. WING_		R 05/15/2008		
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
				BERMARLE GTON, DC 2	STREET NW 20008			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETE DATE		
{ 500}	Continued From pa	age 5		{1 500}				
	(Reference Federa W102, W104, W12	al Deficiency Report C 22, and W127)	Citations					